

*Health workers like
this Kenyan nurse,
Teresa Mugambi,
are the backbone of
HIV treatment and
care service delivery.*




STRENGTHENING HIV SERVICE DELIVERY

Studies focus on care and treatment in India, Kenya, and South Africa

In the ongoing battle against HIV, medical advancements have played a critical role in preventing infections, managing the disease, and saving lives. With key developments such as rapid HIV tests and antiretroviral therapy (ART), there is new hope for the estimated 40 million people currently living with HIV worldwide. And with cutting-edge technology, such as a once-daily treatment pill on the immediate horizon, there is further cause for optimism.

However, despite encouraging advancements, it is important to remember that medical progress alone is not enough to limit the impact of HIV and AIDS in the years ahead. Equally essential to technological breakthroughs is the expansion and strengthening of health systems to deliver them. Effective delivery of treatment, testing, and care and support services must be made a

priority. This requires a renewed commitment to find solutions to overcome the constraints health systems face.

This issue of *Horizons Report* addresses several key topics related to the delivery of quality health services to people living with HIV. These include reducing AIDS-related stigma and discrimination in hospitals, expanding children's access to antiretroviral therapy, protecting health workers from occupational exposure to HIV, and equipping voluntary counseling and testing and ART providers to address alcohol use among clients. The insights and lessons learned discussed in the articles are drawn from operations research conducted in India, Kenya, and South Africa. Each has important implications for policy makers and program managers tasked with strengthening health systems and safeguarding their communities. 

HIV Service Delivery

Inside:



Reducing Stigma and Discrimination
Page 2



Strengthening Pediatric Access to ART
Page 5



Supporting Health Workers
Page 9



Addressing HIV and Alcohol
Page 10

The Population Council implements the Horizons Program in collaboration with the International Center for Research on Women, the International HIV/AIDS Alliance, PATH, Tulane University, Family Health International, and Johns Hopkins University.

REDUCING STIGMA AND DISCRIMINATION

Indian study finds improved attitudes and practices among hospital workers

For people living with HIV, stigma and discrimination can extend into the hospital setting, where it can lead to the denial of care, differential treatment, and disregard for the right to patient confidentiality. Fear of such treatment may cause many people living with HIV to avoid seeking critical health care.

Such is the case in India where AIDS-related stigma and discrimination among health workers in the hospital setting has been documented. For example, a study conducted in Bangalore and Mumbai found that many health providers denied care to HIV-infected patients, labeled admitted patients as HIV-positive, disclosed their HIV status to family members and others without their permission, and excessively used barrier precautions when working with them (UNAIDS 2001).

Recognizing the need to move beyond documentation of the problem, Horizons, SHARAN (an Indian NGO), and the Institute of Economic Growth collaborated with India's National AIDS Control Organization (NACO) and three New Delhi hospitals to design and assess responses to hospital-based stigma and discrimination. This comprehensive study, conducted from 2000–2004, found that tailored interventions to protect the well being of both patients with HIV and health workers contributed to a safer and less stigmatizing and discriminatory hospital environment.

Problem Solving by Partnership

Central to the design of each hospital's response to the problem of AIDS-related stigma and discrimi-



Indian hospital workers aim to ensure the provision of non-stigmatizing health services to all patients regardless of HIV status.

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nation was the use of a self-assessment checklist (Box 1). This tool identifies institutional strengths and weaknesses of services for people living with HIV, and of policies and procedures to prevent occupational exposure to HIV by staff.

During initial meetings with hospital managers and senior staff, the project team discussed findings from baseline research conducted in the study hospitals. These findings focused on the causes and manifestations of stigma and discrimination, and HIV-related attitudes, knowledge, and practices of health workers.

After discussing the findings, hospital managers and senior staff used the checklist to assess the extent to which their facilities followed gold standards to ensure AIDS-related staff safety and a non-stigmatizing and non-discriminatory hospital environment.

Based on the assessment, hospital managers and senior staff developed action plans to address program and policy gaps. Each action plan varied by hospital but included the development and dissemination of guidelines for HIV care and management, sensitivity training of health workers about the needs and rights of people with HIV (led by local AIDS NGOs), expansion and

strengthening of HIV testing and counseling services, and development and dissemination of educational material on infection control procedures and post-exposure prophylaxis (PEP) availability for staff.

“We found that a problem-solving, partnership approach allowed us to work successfully with hospital staff and motivate them to take action to improve the hospital environment,” stated Vaishali Mahendra of Horizons/Population Council, one of the study’s principal investigators.

She explained that when the study began, hospital managers feared that data about discrimination would be used for lawsuits and negative publicity, and AIDS NGOs tended to blame health workers for stigmatizing or discriminatory practices. “We assured the hospitals that the data would be confidential and not reported by hospital, and sensitized NGO staff about the concerns and difficulties of health workers who practice in resource-constrained settings,” Ms. Mahendra added.

Improved Knowledge and Attitudes

To determine the effects of the action plan interventions on hospital worker’s knowledge, attitudes, and practices, the researchers compared baseline and follow-up survey data from more than 800 respondents and conducted follow-up interviews with managers and senior staff.

Overall there were large increases in the understanding of HIV transmission by health workers.

For example, there was a significant increase in the number of ward staff who reported that HIV *cannot* be transmitted by touching someone with HIV or AIDS (from 81 percent to 96 percent).

Hospital managers corroborated positive changes in knowledge and explained how they translated into improved practices. As a doctor and department head reported:

About three or four years back, we had an HIV-positive patient.... The ward staff sprayed DDT [a pesticide] all around the patient’s bed so that the virus would not spread. Now these things do not happen.

The study also found improvements in health workers’ attitudes toward people living with HIV and less support for discriminatory hospital practices. To measure these domains, the researchers developed a 21-item stigma index, which was incorporated into the baseline and follow-up surveys. One of the questions asked whether the respondents agreed or disagreed that HIV spreads due to immoral behavior. Another asked whether patients with HIV should be kept at a distance from other patients.

The researchers analyzed respondents’ scores on the stigma index by dividing them into three categories: low stigma, medium stigma, and high stigma. Overall, the proportion of health workers who were categorized as being the least stigmatizing more than doubled after the intervention (from 12 percent to 27 percent). At the same time, the proportion of respondents in the most stigmatizing category declined considerably (from 24 percent to 7 percent).

HIV Testing and Confidentiality

Health workers reported some improvement in their attitudes and practices regarding informed consent and confidentiality. For example, following the interventions, doctors were more likely to agree that patients should not be tested without their consent (67 percent vs. 37 percent). They were also more likely to seek informed consent the last time they ordered an HIV test (59 percent vs. 40 percent).

Although after the intervention a greater proportion of doctors and nurses said that HIV-positive individuals have the right to decide who should know their serostatus, among ward staff the number who agreed actually declined. Fewer

Box 1 The PLHA-friendly Checklist

This self-assessment tool identifies how well health facilities serve HIV-positive people and provide a safe working environment for staff. The checklist items are organized according to five key domains:

- Access to services
- HIV testing and counseling
- Confidentiality
- Infection control
- Quality of care

Hospital records, survey data, observations, or simply “guesstimates” can be used to rate an institution. To view the complete checklist, go to <http://www.popcouncil.org/horizons/pfechk1st.html> or consult the study’s final report on the Horizons website.

doctors reported informing nurses of patients' positive HIV status, and nurses corroborated this finding. At the same time, this change was not true of nurses, who said they continued to inform ward staff of patients' status.

Better Infection Control

Health workers reported improved understanding and practice of universal precautions and infection control procedures. This includes using gloves whenever drawing blood or starting an IV on a patient. In addition, fewer nurses and ward staff agreed that there was a need to take excessive measures such as burning linens used by HIV-positive patients. The improvements in the use of universal precautions may reflect the fact that fewer health care workers reported shortages of gloves and other supplies following the intervention. Also, more stated that they had access to PEP.

Recommendations

Findings from this research suggest that the actions taken, including education, training, policy formulation, and involvement of AIDS NGOs, contributed to improved knowledge, attitudes, and practices among health workers. However, although the survey data show significant improvements related to the care and management of people living with HIV, which were corroborated by interviews with hospital managers, there is room for refining the intervention. For example, many health care workers continued to feel that they were entitled to know the HIV status of their patients and to share this information with one another even as they expressed increased respect for patient privacy in general. More work is therefore needed to translate changes in attitudes to changes in practices.


Since all cadres of health care workers carry out discriminatory practices, it is critical to involve everyone, from ward staff to hospital superintendents. This includes involvement in initial and refreshing training that provides information on HIV and sensitizes staff to the needs, concerns, and rights of HIV-positive patients. At the same time, these efforts must be accompanied by poli-



Informed consent for HIV testing and the right to patient confidentiality are hallmarks of the hospital intervention in India.

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cies, information, and supplies that create a safe working environment for health workers.

The results of the study encouraged the collaborating hospitals in New Delhi to scale up the intervention hospital-wide to all departments and staff. NACO endorsed the use of the checklist in all public hospitals and disseminated it to all the State AIDS Control Societies in the country. The study has received worldwide attention as one of the few hospital-based interventions to counter stigma and discrimination, including endorsement from UNAIDS and the International Council of Nurses. In addition, the intervention tools are being adapted for other countries' use. 

References

UNAIDS. 2001. "India: HIV and AIDS-related discrimination, stigmatization and denial," *UNAIDS Best Practice Collection*, prepared by Shalini Bharat, with Peter J. Aggleton and Paul Tyrer. Geneva: UNAIDS.

This article was written by Hena Khan and Ellen Weiss, in conjunction with members of the research team, which at the time of the study included Vaishali S. Mahendra, Laelia Gilborn, and Celine Daly of Horizons/Population Council; Bitra George, Luke Samson, Rupa Mudoi, and Sarita Jadav of SHARAN; Indrani Gupta of the Institute of Economic Growth; and Shalini Bharat, consultant from the Tata Institute of Social Sciences.

For more information about this study, contact Vaishali Mahendra (vmahendra@popcouncil.org) or go to www.popcouncil.org/horizons for a final report on this research.

WHERE ARE THE CHILDREN?

Strengthening pediatric access to ART in South Africa

A grandmother stands in line outside of a pharmacy, firmly grasping a little girl's hand. In her other hand is a yellow card, a prescription for the child that the doctor at the clinic gave her with detailed instructions. It's a struggle to remember all the numbers he mentioned, and she hopes the pharmacist will take a few moments to go over the new dosing for the drugs and give her some tips on how to measure them correctly. Because these medicines—the ones that they call antiretrovirals (ARVs)—have become her entire hope for the future.

Just weeks ago her granddaughter was in the wards of a South African hospital, barely clinging to life. It was then that the doctors first told her that the seriously ill three-year-old was HIV-positive. But now, with the help of the clinic staff and the lifesaving drugs, her granddaughter has a chance at survival. She is one of the lucky ones.

The unfortunate reality is that while many adults have benefited from treatment initiatives in sub-Saharan Africa, children have been largely ignored or excluded. AIDS sadly remains one of the leading causes of death among children under the age of five years in the region.

While efforts to get more children on treatment are increasing, important information is lacking to guide program and policy implementation. For example, there has been little documentation of experiences in the identification, treatment, and management of young children who are HIV-positive, and scarce information about how communities, caregivers, and health providers can work together to improve access to treatment for these children.

To address these gaps, the Horizons Program and the University of Cape Town conducted a rapid situational analysis in 2005 of pediatric HIV treatment sites in South Africa. In 2003, the South African government approved a plan for a national HIV treatment program with the goal of at least one service delivery point in each district providing ARVs. The guidelines emphasized providing treatment for both adults and children, and based on reports from a number of managers of sites who were the first to provide pediatric HIV care, the initial effort did result in a significant number of children on treatment. This was especially important in a country where AIDS is the cause of an estimated 40 percent of deaths in children under five years of age (Dorrington et al. 2004). The rapid situational analysis details what is happening on the ground—challenges and lessons learned at key pediatric HIV care sites in South Africa—in order to understand how children have been affected

In a country where 40 percent of deaths in children under age five are attributed to HIV, expanding pediatric access to treatment is critical.



NATHAN GOLON

by the ARV rollout and what can be done to reach many others who still need treatment.

Study Methods

The researchers employed qualitative and quantitative methods to collect data at ARV program sites. They conducted facility observations and interviewed facility managers, health workers (doctors, nurses, pharmacists, social workers, counselors, and dieticians), and caregivers of children on ARVs. At a total of 16 sites offering pediatric ARV services, 7 facility managers, 67 health providers, and 126 caregivers were interviewed.

The 16 sites varied in their overall character and location within the health system, including, for example, a pediatric clinic at a tertiary institution in an urban setting and a combined adult and pediatric clinic at a primary level rural facility. As of 31 March 2005 the sites were providing ART to approximately 1,300 children. About 60 percent of these children were under six years of age.

An Environment of Constraints

All facility managers and health care workers who were interviewed about their experiences and perceptions of the ARV rollout spoke of the challenges they faced in their effort to expand access to treatment for HIV-infected children. Across all facilities, respondents repeatedly cited a lack of staff as a major obstacle to reaching more children with the treatment they need.

Health care workers viewed a lack of specific pediatric training as a serious setback. Most doctors reported having received limited or no formal training in the area of pediatric HIV management, even during any ARV rollout training they received. Instead, they generally relied on self-study, such as on-line courses and reading, and mentorship from specialists to build their skills in the area. Nurses also had varying levels of HIV-specific experience and limited pediatric training, with the majority receiving on-the-job training in these areas from doctors.

This lack of training in managing ARVs for children has resulted in low levels of confidence in treating children among many service providers. As one doctor in an urban tertiary care site explained:

A lot of doctors are not willing to work with children and are scared of the rollout, they

think that with children it's more difficult.... I know for instance our sisters [nurses] don't see children and some of the doctors don't see children.

Nurses across study sites were often reluctant to draw blood from children under the age of six, a major barrier to the rollout of ARV treatment for children and infants. A fieldworker's observation at a district hospital site underscored this issue:

Currently nurses are refusing to take blood on all children less than six years which impacts negatively on the screening process for ARV readiness. The children now have to be screened by the doctors in the ARV clinic, sent back to the fully booked drug readiness program, and then back to the ARV clinic for their ARV treatment to be initiated.

In addition, some nurses found managing ARVs for very young children challenging because the dosing calculations are complicated and change frequently as children grow.

At the same time, working with older children involves other challenges. As Desireé Michaels of the University of Cape Town, principal investigator of the study, explained, "Health workers need specific skills and strategies to cope with the growing number of young chronic care patients. Our primary health care system is not currently set up for the long-term care of adolescents."

Finding and Treating Children

Health workers were interviewed about the referral of children to their care and the identification of HIV-infected children in need of treatment. The majority of children on treatment were referred by primary care facilities or by hospital in-patient wards when they presented with clinical symptoms. As a result, a large number of these children were ill when they began treatment. Results from the caregivers survey supported these findings—most of the children had been tested for HIV because they were chronically ill or hospitalized. Only a few patients were brought in for testing and care by their parents who were receiving treatment.

Health workers agreed that prevention of mother-to-child HIV transmission (PMTCT) programs, primary care clinics, and VCT services were ideally the optimal sources of treatment referral for

the majority of HIV-infected children. They noted that there is often a breakdown in the follow-up of an HIV-exposed infant from when the mother delivers until services are rendered at another health facility, such as routine immunizations at a primary care clinic. One doctor at a peri-urban tertiary level care facility shared his frustration over the system:

We know there are children from the PMTCT program who should have been on ARVs so we are grossly undersupplying ARVs to children and our PMTCT program is not working at this site [to identify these children] and as a result children are dying....

In addition, doctors at tertiary institutions stressed that primary level clinics should be the place where children are identified, assessed, and treated and that their only contact with tertiary institutions should be for complications and hospitalization. As a doctor at an urban tertiary care facility noted:

...I think [our] role in the program is to support, mentor, and develop capacity of...primary sites when it comes to the management of children requiring ARVs. [Our] specific clinic function will be the management of more complicated cases, where patients are ill, or for the very young children under six months but certainly [tertiary institutions] are not appropriate for the management of children who are well and stable on ARVs....

Primary level clinics should be the place where children are identified, assessed, and treated.

However, assessing and initiating treatment of children requires specific skills such as blood taking from infants. Beyond that there is the need for CD4 counts and viral load tests, which require laboratory services. While recognizing that primary care is most accessible to the community, health providers also recognized the current lack of capacity at that level to fulfill the range of services required to successfully identify and provide ARVs to children.

Involving the Community

Providing treatment to children is additionally complicated because of the need to involve caregivers in the entire process—from diagnosis, referral, and initiation of treatment to regular follow-up care and consistent administration of the drugs. During interviews health workers mentioned a number of socioeconomic barriers that their patients face that negatively impact access and adherence to treatment by children. For example, the majority of children in the country are managed at secondary and tertiary health care centers or at dedicated HIV treatment facilities, which are not necessarily located near where they live. The cost of transport can become a barrier to clinic visits.

The circumstances surrounding a child's living arrangements can be an obstacle. Social workers reported that a large bulk of their work entailed ensuring that caregivers can access government grants, such as child support, care dependency, and foster child grants. But access to government grants by caregivers for themselves or on behalf of children is hampered by a lack of identity documents and birth certificates or because many children do not have legal guardians. The ill health and/or death of parents can impact negatively on a child's likelihood of receiving treatment and/or continuing to receive their medication. Multiple caregivers and instability of residence can add to the challenge of continuing many children on treatment.

Community awareness also remains a pervasive challenge to a successful pediatric ARV rollout. In some sites it was reported that community members were not aware that ARV services were available or recommended for children. In fact, some doctors shared the perception that there is widespread skepticism surrounding treatment of children and concerns over negative effects of the drugs on them.

Interestingly, when asked what they saw as the main ways to increase treatment access for children, most nurses interviewed did not mention mechanisms within the health system but rather community interventions such as public awareness campaigns and patient, caregiver, and teacher education regarding the availability and benefits of treatment for children. More than one respondent emphasized the need for information to give patients about ARVs and how they can benefit

children in particular. As a nurse in a peri-urban tertiary level facility noted:

I'm sure the ARV rollout started before community mobilization, especially in rural areas, because they don't know about ARVs, even if it's for the adult. Also the fact that these children, most of these children you'll find that it's not their mothers who look after them, it's the grannies, it's the people who have no knowledge of HIV and AIDS...who didn't even know that the child is HIV-positive....

Recommendations

Despite having made progress in meeting the treatment needs of HIV-infected children, the dedicated professionals surveyed identified many concerns and challenges that need to be overcome to meet the treatment goals of the nation. This will require action from key individuals at institutions, and in provincial and national HIV directorates—actions that are relevant for the Government of South Africa as well as for other countries in the region that are seeking to expand treatment access and service delivery for children.

First, standardized training for doctors and nurses from institutions at all health care levels must be implemented to give them the expertise and clinical competence to manage young children.


Second, links between PMTCT programs and other childhood and development services must be strengthened so that HIV-exposed children do not get lost in the system. Preventing pediatric HIV infection through a comprehensive PMTCT program remains the most effective strategy to modify the course of the pediatric HIV epidemic in South Africa. However, there still will be children who are exposed to HIV and subsequently are in need of care and treatment. Identifying and monitoring these HIV-exposed children from birth will ensure early intervention and maximize benefits to the children's health while minimizing the burden to the health system.

Third, national pediatric adherence guidelines need to be developed that emphasize treatment literacy training targeted to caregivers of pediatric patients as well as the provision of medication administration tools, such as color-coded bottles and dosing syringes. These will help ensure the high levels of adherence critical for achieving the

goal of ART—survival and improved quality of life. In addition, family-centered models of care should be considered to encourage adherence and the integration of services.

Fourth, routine statistics that disaggregate children by age and sex should be collected from all sites in South Africa to flag areas that are either not treating children or adolescents or are falling below acceptable enrollment rates. These areas could then be targeted for appropriate support.

Finally, the Department of Health should take the lead in bringing together other key players to foster a collaborative effort to provide social support and develop interventions for children without regular or reliable caregivers, and to promote community awareness of treatment through information dissemination campaigns.

Results from the rapid situational analysis are currently being disseminated to the study sites to guide them in strengthening their services. They are also being shared with advocacy groups and government policymakers to inform their ongoing ARV rollout planning processes. Horizons is planning a follow-on study that will examine family-centered models of service delivery and the identification of orphans and vulnerable children in the community in need of care. 

References

Dorrington, R.E., et al. 2004. *The Demographic Impact of HIV/AIDS in South Africa. National indicators for 2004*. Cape Town: Centre for Actuarial Research, South African Medical Research Council, and Actuarial Society of South Africa.

This article was written by Hena Khan, in conjunction with members of the research team, which includes Desireé Michaels and Brian Eley of the University of Cape Town and Lewis Ndhlovu and Naomi Rutenberg of Horizons/Population Council.

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STUDIES IN BRIEF

On the Frontlines:

Kenyan health workers confront HIV-related challenges at work and home

Health workers are the backbone of HIV services and key to their successful delivery. But findings from a national study of health workers in Kenya reveal that many are ill equipped to cope with occupational exposure to HIV and the demands of caring for HIV patients both at work and at home.

The study, conducted by the Kenya Ministry of Health National AIDS and STI Control Program with support from Horizons and CDC Kenya, consisted of interviews with a nationally representative sample of 1,897 medical personnel in 245 health facilities located in 28 districts in Kenya. In addition, researchers held 24 focus group discussions with health workers in selected facilities.

The vast majority of health workers in Kenya are worried about occupational exposure to HIV. Ninety-three percent reported that they were “very concerned” about getting infected with HIV on the job. This may be due to the fact that for

many, potential exposure to HIV is a reality that they have already faced. Nearly one in five health workers reported a recent event where they could have been exposed to HIV at work, and among these, half had experienced multiple exposures. To add to their concern, more than half of the health workers indicated that their facility did not have written guidelines about what to do in case of occupational exposure to HIV.

Post-exposure prophylaxis (PEP) is an important recourse for health workers who are inadvertently exposed to HIV. But although 61 percent of health workers said they know what PEP is, only forty percent could correctly describe it. Yet even among those who were knowledgeable, of those who also reported an incident of potential HIV exposure, only 45 percent sought it. The main reasons for not seeking PEP among this group was lack of sufficient information (37 percent) followed by fear of the process and what could follow (28 percent).

Survey findings also revealed that Kenyan health workers often lacked basic infection control items at their facilities, another possible cause of worry about getting infected at work. A third or more of the sample reported inadequate supplies of water, soap, and disinfectant at their workplace. About a fourth of health workers also indicated a lack of sharps containers and gloves at their facilities.

In addition to caring for HIV-positive patients in the workplace, many health workers must confront the disease in their personal lives as well. About a third of health workers surveyed had an immediate family member who was HIV-infected or who had died of AIDS. In addition, one out of every five health workers were caring for an HIV-infected immediate family member at the time of the survey. The greatest burden was in Nyanza province, the province with the highest HIV prevalence in the country, where 59 percent of respondents reported HIV infection among immediate family members.

Occupational risk of exposure to HIV is a serious concern for most health workers in Kenya.



COURT CARNEMARK/WORLD BANK

Despite working in the health field and frequent personal connection to the disease, nearly a third of health workers in Kenya had never been tested for HIV. This includes half of enrolled nurses, who represented the bulk of health care providers in the country.

The low levels of testing were not due to a lack of availability of testing services. In fact, health workers strongly believed that they could take a confidential HIV test at work. However, among those who had not been tested, most (42 percent) said it was because they had “not thought about it.” Nearly a quarter of respondents were afraid of the results and others feared the stigma associated with the disease. Perhaps because of stigma and concerns about confidentiality, 73 percent of respondents were interested in self-testing.


Among health workers involved in HIV testing, those who had been tested reported more confidence in recommending an HIV test, and conducting pre- and post-test counseling and couple counseling and testing.

Recommendations

Data from this national study suggest an urgent need to strengthen infection control supplies, procedures, and guidelines in Kenyan health care facilities. This includes the need to educate health workers about PEP, including how to use it and access it as well as to overcome fears of taking it.

In addition to addressing the risks of occupational exposure, health workers with HIV-infected relatives need to be supported to cope with the additional burden of providing care to HIV-infected persons in and outside their workplace. Finally, there is a need to support and encourage HIV testing among health workers, which may include exploring the possibilities of self-testing as an option.

As Karusa Kiragu of Horizons/PATH, a principal investigator of the study summarized, “The health care system must not only care for the patients but also ensure that its human capacity remains strong and motivated. Health care professionals need a secure and supportive work environment if they are to be effective partners in combating the HIV epidemic.”

For more information about this study, please contact Karusa Kiragu (kkiragu@pcnairobi.org). 

—Hena Khan

Alcohol and HIV Services: Study finds Kenyan counselors need support to handle alcohol use among clients

Voluntary counseling and testing (VCT) services play a vital role in HIV prevention and care. By determining and discussing an individual’s serostatus, VCT can promote the adoption of HIV prevention behaviors and facilitate early initiation of antiretroviral therapy (ART). However, an important challenge facing VCT service providers surrounds the use of alcohol among their clients.

Alcohol use has been associated with high-risk sexual behavior; it reduces inhibitions and self-control, which makes it easier for individuals to engage in risky behavior, such as multiple sex partners and unprotected sex.

A study among clients of rural public clinics in Kenya found that more than half reported “hazardous” drinking behavior, suggesting that alcohol use is a serious problem (Shaffer et al. 2004).

Horizons, in partnership with Liverpool VCT and Care Inc and The Steadman Group, conducted a study in December 2005 to explore the need for integrating alcohol counseling and referral into VCT services, and the preparedness of service providers to address alcohol use among clients accessing Kenyan facilities. The study also queried providers who counsel patients about ART because alcohol use can have a major impact on people living with HIV; drinking alcohol is associated with poor adherence to ART (Samet et al. 2004).

Findings from the study include that alcohol is indeed an issue among VCT and ART clients, and that providers are not prepared to address it in a uniform and systematic way.

The study consisted of focus groups and in-depth interviews with VCT and ART providers, patients on ART, bar patrons, and others. Conducted in Nairobi and Mombasa, the study, although not representative, provides important insights into the issues surrounding alcohol use in the context of VCT and ART services.

VCT counselors reported that it is not uncommon for alcohol users to seek HIV testing while intoxicated to help them cope with learning their HIV status. According to one VCT provider:

Most of them say they drink to get courage...to gain confidence to talk to someone for 45 minutes [during counseling].

Alcohol use among clients can be a challenge for VCT and ART providers in Kenya.

COURT CARNEYMARK/WORLD BANK



In general, people who are intoxicated are not likely to get tested. According to the study informants, these individuals are often turned away by the receptionist and told to come back another day, or only counseled about the test by the provider and then asked to return for testing. However, the decision to test or not depends on the providers' discretion, rather than formal guidelines, and there is no formal referral mechanism. As a counselor recounted about a client who came in for testing while drunk,

...I didn't test him, he had no concentration. I told him to go and come back again. He has never come back.

Another challenge for counselors is how to help female clients who are concerned about their partner's drinking and the fact that it impedes communication about preventing HIV.

...They come and say that the husband takes a lot of alcohol but they don't know how to explain to the husband that they have to use protection during sex....

Study findings suggest that most VCT counselors and ART providers have limited training and skills in alcohol counseling. The current practice of ART providers is to tell their patients to stop drinking. Many are unable to answer questions such as how much alcohol is too much, what types of alcohol are safer to consume, and the relationship between eating well and drinking.

Patients on ART stated a desire for more information on why they should stop drinking, and a

discussion of feasible options. As one patient on ART expressed,


Doctors say do not take alcohol.... But you see you are not told why you should not take alcohol...as a human being when you start feeling better, you will be like 'why not?'.... Drinking in our society is a way of relaxing and entertainment.

VCT and ART providers themselves expressed a need for training in alcohol counseling, citing the need for knowledge to be better equipped to confront different situations.

Next Steps

Study findings document the need to equip VCT and ART providers to offer alcohol counseling and referral as part of service delivery. This will require adequate training of providers to be able to use screening tools to identify clients at risk, to counsel them about alcohol abuse, and to counsel clients about how to deal with partners who abuse alcohol.

Horizons is developing a follow-on intervention study that will offer such training, as well as standardized guidelines for dealing with intoxicated clients. This will allow providers to offer these clients minimal counseling and educational materials and not to lose an opportunity to foster serostatus awareness and HIV risk reduction.

For more information about this study, please contact Caroline Mackenzie (cmackenzie@pcnairobi.org). 

—Hena Khan

References

- Shaffer, S.N. et al. 2004. "Alcohol abuse among patients with and without HIV infection attending public clinics in Western Kenya," *East African Medical Journal* 81:594–598.
- Samet, J.H. et al. 2004. "Alcohol consumption and antiretroviral therapy adherence among HIV infected persons with alcohol problems," *Alcoholism: Clinical and Experimental Research* 28: 572–577.

Horizons Findings in the Literature

Many articles based on findings from Horizons studies have been published in peer-reviewed journals. Here are some recent examples:

Barnes, Carolyn. 2005. "Microcredit and households coping with HIV/AIDS: A case study from Zimbabwe," *Journal of Microfinance* 7(1): 55-77.

Duraisamy, P., A.K. Ganesh, R. Homan, N. Kumarasamy, C. Castle, P. Sripriya, V. Mahendra, and S. Solomon. 2006. "Costs and financial burden of care and support services to PLHA and households in South India," *AIDS Care* 18(2): 121-127.

Kerrigan, Deanna, Luis Moreno, Santo Rosario, Bayardo Gomez, Hector Jerez, Ellen Weiss, Clare Barrington,

and Michael Sweat. 2006. "Effects of environmental-structural interventions on HIV/STI-related risk among female sex workers in the Dominican Republic," *American Journal of Public Health* 96: 120-125.

Magnani, Robert, Kate MacIntyre, Ali Mehyrar Karim, Lianne Brown, and Paul Hutchinson. 2005. "The impact of life skills education on adolescent sexual risk behaviors in KwaZulu-Natal, South Africa," *Journal of Adolescent Health* 26: 289-304.

Rutenberg, Naomi and Carolyn Baek. 2005. "Field experiences integrating family planning into programs to prevent mother-to-child transmission of HIV," *Studies in Family Planning* 36(3): 235-245.

Horizons Symposium Examines Care and Support Services in the Era of Treatment

In November 2005, Horizons held a one-and-a-half day symposium in Johannesburg, South Africa, to discuss strengthening care and support programs and linking them to treatment services. The symposium drew more than 70 program managers, researchers, policymakers, and donors from the region. A report that synthesizes program experiences; research findings; and program, policy, and research recommendations discussed at the meeting is available online at: www.popcouncil.org/pdfs/horizons/sacssymp.pdf

HorizonsReport

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